EXHIBIT A

DOH-1961 (8/2015)

NEW YORK STATE
DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

STATE FILE NUMBER

RECORDED DISTRICT: 1465
REGISTER NUMBER: 646

DECEDENT

1. NAME: FIRST: Florence | MIDDLE: J. | LAST: Dulski
2. SEX: MALE ☐ FEMALE ☒
3A. DATE OF DEATH: MONTH 03 | DAY 09 | YEAR 2019
3B. HOUR: 4:45 p.m.
4A. PLACE OF DEATH (Check one): HOSPITAL DOA ER ☐ | HOSPITAL OUTPATIENT ☐ | HOSPITAL INPATIENT ☐ | NURSING HOME ☐ | PRIVATE RESIDENCE ☒ | HOSPICE FACILITY ☐ | OTHER (Specify) ☐
4B. IF FACILITY, DATE ADMITTED: MONTH --- | DAY --- | YEAR ---
4C. NAME OF FACILITY: (If not facility, give address) 3640 James Street
4D. LOCALITY: (Check one and specify) CITY ☐ VILLAGE ☐ TOWN ☒ Hamburg
4E. COUNTY OF DEATH: Erie
4F. MEDICAL RECORD NO.: NA
4G. WAS DECEDENT TRANSFERRED FROM ANOTHER INSTITUTION? (If yes, specify institution name, city or town, county and state) NO ☒ YES ☐
5. DATE OF BIRTH: MONTH | DAY | YEAR
6A. AGE IN YEARS: 92 yrs.
6B. IF UNDER 1 YEAR ENTER: months | days
6C. IF UNDER 1 DAY ENTER: hours | minutes
7A. CITY AND STATE OF BIRTH: (If not USA, Country and Region/Province) Lackawanna, NY
7B. IF AGE UNDER 1 YEAR, NAME OF HOSPITAL OF BIRTH: ---
8. SERVED IN U.S. ARMED FORCES? (Specify yes/no) NO ☒ 0 YES ☐ 1
9. DECEDENT OF HISPANIC ORIGIN? (Check the boxes that best describe whether the decedent is Spanish/Hispanic/Latino.)
A ☒ No, not Spanish/Hispanic/Latino | B ☐ Yes, Mexican, Mexican American, Chicano
C ☐ Yes, Puerto Rican | D ☐ Yes, Cuban
E ☐ Yes, Other Spanish/Hispanic/Latino (Specify)
10. DECEDENT'S RACE: (Check one or more races to indicate what the decedent considered himself or herself to be.)
A ☒ White/Caucasian | B ☐ Black or African American | C ☐ Asian Indian | D ☐ Chinese
E ☐ Filipino | F ☐ Japanese | G ☐ Korean | H ☐ Vietnamese
J ☐ Native Hawaiian | K ☐ Guamanian or Chamorro | L ☐ Samoan
M ☐ American Indian or Alaska Native (specify)
P ☐ Other Asian (specify) | R ☐ Other Pacific Islander (specify)
S ☐ Other (specify)
11. DECEDENT'S EDUCATION: (Check the box that best describes the highest degree or level of school completed at the time of death.)
1 ☐ ≤ 8th grade | 2 ☐ 9th-12th grade; no diploma | 3 ☒ High school graduate or GED
4 ☐ Some college credit, but no degree | 5 ☐ Associate's degree | 6 ☐ Bachelor's degree
7 ☐ Master's degree | 8 ☐ Doctorate/Professional degree
12. SOCIAL SECURITY NUMBER:
13. MARITAL STATUS: NEVER MARRIED ☐ 1 | MARRIED ☐ 2 | WIDOWED ☒ 3 | DIVORCED ☐ 4 | SEPARATED ☐ 5
14. SURVIVING SPOUSE: (Enter birth name of spouse if married or separated.) ---
15A. USUAL OCCUPATION: (Do not enter retired) House Keeping
15B. KIND OF BUSINESS OR INDUSTRY: Housewife
15C. NAME AND LOCALITY OF COMPANY OR FIRM: Own Home
16A. RESIDENCE: (State or Country if not USA) New York
16B. County or Region/Province if not USA: Erie
16C. LOCALITY: (Check one and specify) CITY ☐ VILLAGE ☐ TOWN ☒ Hamburg
16F. IF CITY OR VILLAGE, IS RESIDENCE WITHIN CITY OR VILLAGE LIMITS? ☒ YES ☐ NO IF NO, SPECIFY TOWN:
16D. STREET AND NUMBER OF RESIDENCE: 3640 James Street
16E. ZIP CODE: 14219
17. BIRTH NAME OF FATHER / PARENT: FIRST Joseph | MI | LAST Kaszuba
18. BIRTH NAME OF MOTHER / PARENT: FIRST Mary | MI | LAST Dusza

DISPOSITION

19A. NAME OF INFORMANT: Robert S. Dulski
19B. MAILING ADDRESS: (Include zip code) 8 Schilling Court Lancaster, New York 14086
20A. 1 ☐ BURIAL 2 ☐ CREMATION 3 ☐ REMOVAL 4 ☐ HOLD 5 ☐ DONATION 6 ☒ ENTOMBMENT | MONTH 03 | DAY 15 | YEAR 2019
20B. PLACE OF BURIAL, CREMATION, REMOVAL OR OTHER DISPOSITION: Holy Cross Cemetery
20C. LOCATION: (City or town and state) Lackawanna, New York
21A. NAME AND ADDRESS OF FUNERAL HOME: The Colonial Memorial Chapels, Inc. 3003 South Park Avenue Lackawanna, NY 14218
21B. REGISTRATION NUMBER: 01676
22A. NAME OF FUNERAL DIRECTOR: Matthew J. Pasnik
22B. SIGNATURE OF FUNERAL DIRECTOR: Matthew J. Pasnik
22C. REGISTRATION NUMBER: 12795
23A. SIGNATURE OF REGISTRAR:
23B. DATE FILED: MONTH 3 | DAY 11 | YEAR 2019
24A. BURIAL OR REMOVAL PERMIT ISSUED BY:
24B. DATE ISSUED: MONTH 3 | DAY 11 | YEAR 2019

ITEMS 25 THRU 33 COMPLETED BY CERTIFYING PHYSICIAN -- OR -- CORONER/CORONER'S PHYSICIAN OR MEDICAL EXAMINER

CERTIFIER

25A. CERTIFICATION: To the best of my knowledge, death occurred at the time, date and place and due to the causes stated.
Certifier's Name: AGNES V. QUEBRAL | License No.: 250185 | Signature: Agnes V Quebral | Month 3 | Day 11 | Year 2019
Certifier's Title: 0 ☒ Attending Physician | 0 ☐ Physician acting on behalf of Attending Physician | 1 ☐ Coroner | 2 ☐ Medical Examiner / Deputy Medical Examiner
Address: 1900 RIDGE RD STE 130 WEST SENECA NY 14224
25B. If coroner is not a physician, enter Coroner's Physician's name & title: | License No.: | Signature: | Month | Day | Year
25C. If certifier is not attending physician, enter Attending Physician's name & title: | License No.: | Address:
26A. Attending physician attended deceased: FROM Month 12 | Day 27 | Year 2013 TO Month 3 | Day 9 | Year 2019
26B. Deceased last seen alive by attending physician: Month 10 | Day 25 | Year 2018
26C. Pronounced Dead ON: Month 3 | Day 9 | Year 2019 AT Time 4:45 P M
27. MANNER OF DEATH: NATURAL CAUSE ☒ 1 | ACCIDENT ☐ 2 | HOMICIDE ☐ 3 | SUICIDE ☐ 4 | UNDETERMINED CIRCUMSTANCES ☐ 5 | PENDING INVESTIGATION ☐ 6
28. WAS CASE REFERRED TO CORONER OR MEDICAL EXAMINER? 0 ☒ NO 1 ☐ YES
29A. AUTOPSY? NO ☒ 0 YES ☐ 1 REFUSED ☐ 2
29B. IF YES, WERE FINDINGS USED TO DETERMINE CAUSE OF DEATH? 0 ☐ NO 1 ☐ YES

CONFIDENTIAL — SEE INSTRUCTION SHEET FOR COMPLETING CAUSE OF DEATH — CONFIDENTIAL

CAUSE OF DEATH

30. DEATH WAS CAUSED BY: (ENTER ONLY ONE CAUSE PER LINE FOR (A), (B), AND (C).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. IMMEDIATE CAUSE:
(A) CHRONIC CONGESTIVE HEART FAILURE
DUE TO OR AS A CONSEQUENCE OF:
(B) SEVERE AORTIC STENOSIS
DUE TO OR AS A CONSEQUENCE OF:
(C)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN PART I (A): HYPOTHYROID, GERD, HYPERCHOLESTEROLEMIA
DID TOBACCO USE CONTRIBUTE TO DEATH? 0 ☒ NO 1 ☐ YES 2 ☐ PROBABLY 3 ☐ UNKNOWN
31A. IF INJURY, DATE: MONTH | DAY | YEAR | HOUR:
31B. INJURY LOCALITY: (City or town and county and state)
31C. DESCRIBE HOW INJURY OCCURRED:
31D. PLACE OF INJURY:
31E. INJURY AT WORK? NO ☐ 0 YES ☐ 1
31F. IF TRANSPORTATION INJURY, SPECIFY: 1 ☐ Driver/Operator 2 ☐ Passenger 3 ☐ Pedestrian
32. WAS DECEDENT HOSPITALIZED IN HOSPITAL OR NURSING HOME WITHIN 2 MONTHS OF DEATH? NO ☐ YES ☐
33A. IF FEMALE: 0 ☒ Not pregnant within last year | 1 ☐ Pregnant at time of death | 2 ☐ Not pregnant, but pregnant within 42 days of death
33B. DATE OF DELIVERY: MONTH | DAY | YEAR

DATE OF DEATH: AM PM
TIME OF DEATH:
For use by physician or institution.

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Safety Features Used In This Form

1. **Watermark on back is visible when document is held up to a light source.**
2. **Press number on document.**
3. **"VOID" appears on photocopies made on either a black and white or color photocopier.**

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THIS IS TO CERTIFY TO BE A TRUE COPY OF A RECORD ON FILE IN THE OFFICE OF VITAL STATISTICS TOWN OF HAMBURG, ERIE COUNTY, STATE OF NEW YORK.

REGISTRAR

DATE MAR 11 2019